



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELISA GARZA SANCHEZ MD

MFDR Tracking Number

M4-16-1340-01

MFDR Date Received

January 20, 2016

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative

Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TDI/DWC when an OIEC or an insurance company has a request to complete a questionnaire... the proper code to use is 99080 (no modifier) and the bill should go to the insurance company... This report being submitted as medical proof is a comprehensive report in addition to any of the regular reports. It was in fact a response to a request from The Office of Injured Employee Counsel."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "To be consistent with the applicable rule governing code 99080 Texas Mutual is compelled to deny payment... Novitas, the Medicare intermediary for Texas, indicates code 99080 has a 'B' status... Further, Rule 134.120(a) states '(c) Upon request, the health care provider shall provide the injured employee, or the injured employee's representative, an initial copy of the medical documentation without charge. The requestor shall reimburse the healthcare provider for subsequent request of the same medical documentation.' There is no information in the DWC60 packet from the requestor indicating the medical report of causation is not the initial request from Office of Injured Employee Counsel. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2015	99080	\$350.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §404.002 establishes Office of Injured Employee Counsel administrative attachment to Texas Department of Workers' Compensation.
3. 28 Texas Administrative Code §134.120 sets out guidelines for reimbursement for medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.
 - W3 – In accordance with TDI-DWC rule 134.804. This bill has been identified a request for reconsideration.
 - CAC – 97 – The benefit for this service is included in the payment/allowance for another service/procedure

that has already been adjudicated

- CAC – 193 – Original payment decision is being maintained
- 284 – No allowance was recommended as this procedure has a Medicare status of “B” (bundled).
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions
- 724 – No additional payment after a reconsideration of service.

Issues

1. Is the Office of Injured Employee Counsel part of the Division of Workers’ Compensation
2. Was the definition of narrative report met?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent in their position stated, “The requestor billed Texas Mutual for a 10/26/2015 report provided at the request of the Office of Injured Employee Counsel.” The “requestor” of the report is not Texas Mutual and not the Division. Per Texas Labor Code §404.002 (b), “The office is administratively attached to the department but is independent of direction by the commissioner, the commissioner of insurance, and the department...” The Division finds that the Office of the Injured Employee Counsel is not the Division of Workers Compensation (DWC).
2. Per 28 Texas Administrative Code 134.120 (g) Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or equivalent electronic document format. Clinical or progress notes do not constitute a narrative report.
3. Review of the submitted documentation finds the request was not made by the carrier or the Division. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	February 5, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.